Confidential

ADMINISTRATIVE REVIEW

DEATH OF MR. BRIAN SINCLAIR

OVERVIEW

- On Sunday, September 21, 2008, at approximately 0051 hours, Mr. Brian Sinclair was pronounced deceased in the resuscitation room of the Emergency Room at the Health Sciences Centre Winnipeg. He had not been triaged or registered as a patient during the approximately 34 hours that he was present in the Emergency Room waiting area.

- This Administrative Review has been undertaken to determine the facts surrounding Mr. Sinclair's death, to determine the steps required to be taken in the short term to address gaps in the system pending completion of the Critical Incident Review process and the Inquest called into Mr. Sinclair's death and to determine whether any individual (s) acted or omitted to act in a manner warranting disciplinary action, coaching, direction or training.

PROCESS

- This Administrative Review was undertaken in two phases. Phase One was undertaken on September 22, 23 and 24, 2008 by Helga Bryant, Vice-President and Chief Nursing Officer, Health Sciences Centre and Laverne Sturtevant, Director of Patient Services, Adult Emergency, Health Sciences Centre. Phase One of the review was intended to ascertain the facts of this 34 hour period as they were then known and to make preliminary recommendations to address identified gaps in the system pending completion of the Critical Incident Review process. As a result of Phase One of this Review, several recommendations were made and implemented immediately, as set out below in the section entitled "Action Taken to Date". Through this process it was determined that no individual had acted or omitted to act in a matter requiring immediate removal from their position pending further investigation.

- Phase Two of this Administrative Review consisted of in-depth interviews with staff working in the Department during this 34 hour period and consideration of whether any

individual(s) had acted or omitted to act in a manner warranting disciplinary action, coaching, direction or training. This process consisted of interviews with nursing, support, Security and Housekeeping staff, over the four duty shifts during this time period.

STATEMENT OF FACTS

- On September 19, 2008 at approximately 1450 hours, Mr. Brian Sinclair arrived at the Adult Emergency Department at the Health Sciences Centre Winnipeg in a white van driven by and unidentified male. The driver of the van pushed Mr. Sinclair, a bilateral amputee with communication challenges, in his wheelchair to the triage desk and departed without speaking with anyone.

- At approximately 1454, Mr. Sinclair was spoken to by a unit assistant performing the Triage Aide function (the "Triage Aide") at the triage desk. The Triage Aide is seen on the security videotape to write something down, but has no independent recollection of the interaction.

- By way of general background, when Triage Nurses are busy triaging other patients, the Emergency Department's usual procedure when a person requiring medical care presents to the Department is to record the name, time and entrance complaint of those entering the Department on a triage list. When a Triage Aide is on duty and available, the name may be recorded by the Triage Aide. This list is provided to the Triage Nurses, who call patients from this list back to the triage desk. In the event that the patient does not answer, it is their practice to call a further two times, with reasonable intervals in between. If there is no response after the third call, the patient's name is crossed out and marked "LNS" (left not seen). Conversely, once the patient presents to triage, the name is also crossed off the list. Once all the names on page of the list have been crossed off, that page of the list is discarded.

- After interacting with the Triage Aide, Mr. Sinclair wheeled himself over to the volunteer desk adjacent to the Security Desk. Approximately twenty minutes later, Mr. Sinclair wheeled himself past the Triage Desk, back to the Security Desk and towards the waiting room. About twenty five minutes later, Mr. Sinclair wheeled himself from the waiting room area to the Security Desk, which was becoming congested. Approximately three minutes later, the Security Officer on duty asked Mr. Sinclair to return to the waiting room due to traffic congestion, which he did. Mr. Sinclair wheeled himself to the area by the television, in the second row.

- Mr. Sinclair remained in this general area of the waiting room from 1540 hours on Friday afternoon, September 19, 2008 until he was discovered deceased on Sunday, September 21, 2008 at approximately 0051. During this period, Mr. Sinclair was not triaged or registered, nor is there

any evidence that he asked anyone for medical assistance. He was seen to move his wheelchair on his own on several occasions up to an including Saturday, September 21, 2008 in the early afternoon.

- Several staff members were on duty during this period who knew Mr. Sinclair from previous visits to the Adult Emergency Department, however, some of them did not see Mr. Sinclair during this period. Conversely, several staff members who did not know Brian Sinclair observed him in the waiting room, with some interacting with him during this time. Tragically, none were aware that Mr. Sinclair was awaiting medical treatment and had not been triaged. When they discovered later that this was, in fact, the case (subsequent to his death), they were devastated.

- Upon examination by the Chief Medical Examiner, it was determined that Mr. Sinclair died from a peritoneal infection arising from a blocked catheter. A Critical Incident was declared by the Winnipeg Regional Health Authority and the Health Sciences Centre and the Chief Medical Examiner called an Inquest into Mr. Sinclair's death.

STAFF OBSERVATIONS OF AND INTERACTIONS WITH MR. SINCLAIR

- From the time Mr. Sinclair arrived at the Emergency Department on Friday, September 19, 2008 at 1450 hours to the time he was pronounced deceased on Sunday, September 22, 2008 at 0051 hours, there were at least 17 observations of Mr. Sinclair by staff, including at least 4 interactions. Staff on duty in the front of the Emergency Department during this period included Triage Nurses, Clinical Resource Nurses (who were functioning as Charge Nurses), a Triage Aide, a Reassessment Nurse, a Nurse Practitioner, Nurses working in the Minor Treatment area, Registration Clerks, Security Patrol Officers and Housekeeping Aides. These observations included observations by two Triage Nurses, the Reassessment Nurse, the Nurse Practitioner, a Housekeeping Aide and five Security Patrol Officers, as well as interactions with the Triage Aide, a Nurse working in the minor treatment area and two Security Patrol Officers.

- While collectively these interactions and observations are clearly symptomatic of systemic gaps which must be and are being addressed, it is anticipated that the recommendations arising from the Critical Incident Review process will be the subject of ongoing discussion and review administratively once that process is completed. In addition to ascertaining the facts and implementing the actions that have been undertaken to date (see below), the matter for determination within the scope of this Review is whether any of the individual employees on duty within the Emergency Room during this 34 hour period acted or omitted to act in such a manner that disciplinary action, coaching, direction or training is required on an individual basis.

- In considering this issue, it is important to note that up until the time of this tragic incident, the Emergency Department, like most emergency departments in Canada and abroad, was organized around the premise that patient care commences with the patient being triaged. Mr. Sinclair's death and the circumstances surrounding his presence in the waiting room of the Emergency Department have led to a review of this fundamental premise. In considering the actions or inaction of individual staff at that time, though, the circumstances and premises as they existed then are vitally important.

- Mr. Sinclair did approach the Triage Desk, where the Triage Aide was seen on the security videotape to write something down. It is important to note that Mr. Sinclair's speech was reported by several staff who knew him to be hard to understand, describing it as "muttering". He was also reportedly cognitively challenged. The Triage Aide reports having no independent recollection of this interaction. The Triage List was discarded on the evening of September 19, 2008, as is normal practice.

- Mr. Sinclair proceeded to the waiting area by the Security Desk on his own. The usual practice of the Triage Nurses is to work from the triage list and to call patients up to be triaged in the order they appear on the triage list, unless a more urgent case presents which requires more immediate attention. The name on the list is called, usually by the Triage Nurse, but sometimes by the Triage Aide. If the patient does not come from the waiting room to the triage area, the letters NA ("no answer") are written beside the name, along with the time, and the next patient on the list is called and triaged, and then the patient will be called again. If the patient still does not present, the Triage Nurse will proceed to triage the next patient on the list and a final call will be made. If the patient does not present after the third call, the patient's name will be crossed off the list and the letter "LNS" (left not seen) marked beside the name, with the time.

- In this case, none of the Triage Nurses, nor the Triage Aide, on duty during this 34 hour period have a recollection of Mr. Sinclair's name being on the triage list or of calling his name. Of note, Mr. Sinclair was well known to one of the Triage Nurses on duty on Friday afternoon when he presented to the Emergency Department. She had known him since he first started coming to the Department when he was 16 years old. This Triage Nurse recalls that the list had been worked through by 1800 hours on Friday, September 19, 2008, as she recalls commenting to the other Triage Nurse at that time that they had finally caught up.

- Based on the evidence available, it is not possible to conclusively determine why Mr. Sinclair was not triaged on Friday, September 19, 2008. It is possible that his name was taken down and called and that he did not hear his name being called. It is equally possible that the Triage Aide misunderstood the name given by Mr. Sinclair, given his speech impediment, and that Mr. Sinclair's name may not have been called. However, both of these possibilities are in the realm of speculation.

- At approximately 1540 hours, about 50 minutes after his arrival in the waiting room, the Security Patrol Officer on duty asked Mr. Sinclair if he would please move to the area of the waiting room by the television, as the area where he was sitting was becoming congested. This was Mr. Sinclair's second interaction with staff since his arrival. Mr. Sinclair moved as requested. The Security Patrol Officer reported that Mr. Sinclair did not appear unwell at that time.

- There were no further known observations of or interactions with Mr. Sinclair during the remainder of that shift, which ended at 1930 hours on Friday, September 19, 2008, when the shift of Triage Nurses, the Charge Nurse and Security Patrol Officers changed over.

- In general, patients are triaged within an hour of presentation to the Emergency Department. When the night shift nurses came on duty, there were only a few names on the list. The Triage Nurse on duty at that time recalls that the Triage Aide said to her that the first page of the list was completed and that page of the list was disposed of, as was normal practice.

- From this point forward, there were at least 15 further observations of Mr. Sinclair by staff, including 2 additional interactions. During the early morning hours of September 20, 2008, one of the nurses in the Minor Treatment Area who knew Mr. Sinclair approached him and said words to the effect of "Hey, Brian. How's it going?" He acknowledged her with a mumble, and she returned to her work. She reported that he did not appear to be in distress and that she mistakenly assumed that he was there for shelter, or that he had been seen and discharged.

- During the afternoon of Saturday afternoon, September 20, 2008, shortly before 1330 hours, Mr. Sinclair began to vomit. The Housekeeping Aide observed him while cleaning up the vomit. At that time, Mr. Sinclair had a kidney basin, which had been provided to him by a Security Patrol Officer. After it became apparent that the kidney basin was not large enough, this Security Patrol Officer approached the Triage Aide and stated that there was a patient in the waiting room who did not look good and needed a larger basin. At that time, the Triage Aide was busy with another patient, so the Security Patrol Officer obtained a large metal bowl from the Housekeeping Aide, which he provided to Mr. Sinclair. When the Triage Aide returned from dealing with the other patient, the Security Patrol Officer told the Triage Aide that he had "taken care of it". By this, the Security Patrol Officer meant that he had taken care of disposing of the vomit and obtaining a larger bowl. The Triage Aide appears to have taken this to mean that the patient's needs had been taken care of, and accordingly, he did not believe there was any further action to be taken by him in relation to the Security Patrol Officer's earlier comment to him. The Triage Aide has no independent recollection of this conversation.

- Notwithstanding that he had been vomiting, Mr. Sinclair was seen to move his wheelchair on his own in the area that he was sitting. In the early afternoon of September 20, 2009, the Reassessment Nurse saw Mr. Sinclair when he was moving his wheelchair over the bowl. She remarked that he appeared to be okay and that it is not unusual for patients to be

vomiting in the waiting room. She has no further recollection of observing Mr. Sinclair for the remainder of her shift.

- Each of the staff who saw or interacted with Mr. Sinclair during this 34 hour period mistakenly assumed either that he had been triaged already and was awaiting a bed in the back (in the treatment area), that he had been treated and discharged, that he was a patient awaiting pick up under the Intoxicated Persons Detention Act ("IPDA") or that he was just there because he needed a warm place to rest. Tragically, there was little or no communication of these observations amongst each other and Mr. Sinclair was neither triaged nor treated during this time.

- Upon learning of Mr. Sinclair's death, staff were devastated. Many reported having reflected on their observations and interactions with Mr. Sinclair and what might have been had they realized that Mr. Sinclair was awaiting care and had not been triaged. The assumptions that were made, while clearly mistaken, do not appear to have been made with malice.

STAFF INTERACTIONS WITH THE PUBLIC

- Subsequent to Mr. Sinclair's death, two members of the public who were in the waiting room, a husband and wife, came forward to describe their interactions with the Emergency Department staff between approximately 0930 hours on the evening of Saturday, September 20, 2008 and 0051 hours Sunday, September 21, 2008. They indicated that they had been in the Emergency Department the preceding evening, September 19, 2008 and that when they had returned on the evening of September 20, 2008, Mr. Sinclair was still in the same place. The husband stated that he told the Charge Nurse that the man was still there. According to the Charge Nurse, the context for this conversation was that the husband's daughter was being treated and that when he was introduced to the Charge Nurse, he said words to the effect that "You sure are busy here . . . there's a guy in the waiting room who is in the same place as last night when we were here." The Charge Nurse reports that there was no sense of urgency or call to action conveyed during this exchange and that it was not unusual for patients to be in the waiting room on 2 successive evenings for various reasons.

- The husband also reported remarking to a Security Patrol Officer that there was a man in the waiting room who had been there the night before. He acknowledges that he did not gesture to where the man was sitting and he could not recall exactly where he was when he had this conversation with the Security Patrol Officer. It is the husband's recollection that the Security Patrol Officer responded by saying words to the effect "too much paperwork".

- Upon investigation, it was determined that the Security Patrol Officer fitting the description provided by the husband cannot recall this conversation and indicated that the use of these words did not make sense in this context, as there would not have been paperwork to do arising from such a situation. Within the context of a Saturday night in the Health Sciences Centre Emergency Department, the interaction appears to have been unremarkable from the perspective of the Security Patrol Officer. Upon review, it appears that the communication from the member of the public was not conveyed with a sense of urgency or a call to action and that accordingly, there was perhaps a misunderstanding between the two. Of note, this Security Patrol Officer was not assigned to the Adult Emergency Department at that time and was passing through the area at the time the conversation is believed to have taken place.

- It is important to note that the primary focus of the Security function is the preservation of order in the waiting room and accordingly, interactions with those in the waiting room are viewed through this lens. The scope of this function may be an area for further discussion and consideration within a systemic context.

- This Security Patrol Officer indicated that when he passed through the waiting room at approximately 2300 hours on September 20, 2008, he observed Mr. Sinclair, who he had seen there the night before when he was on duty in the Adult Emergency Department. He stated that he approached the Triage Nurse on duty at the time, expressing concern about the patient being in the waiting room as he had been the preceding evening, and that the Triage Nurse indicated to him that he had been discharged and had returned to the Department. The Triage Nurse has no recollection of this interaction with the Security Patrol Officer. She stated that is not unusual, though, for patients to be in the waiting room on successive evenings, after having been seen. Accordingly, that information in and of itself, without information to convey a sense of urgency or a need for action, did not appear to be remarkable from her perspective.

- The wife reported having a conversation with a young nurse in the Minor Treatment Area. She said that there was a man in the waiting room who had been there the night before and that he did not look well. The young nurse replied that sometimes there are people in the waiting room looking for shelter, or who have been discharged. The patient, the woman's stepdaughter replied that the man was probably drunk and the conversation ended. A short time later, the woman returned, saying that she walked in front of the man in the waiting room and that he was pale, slumped over and had lividity in his neck. At that point, the young nurse went to get a more senior nurse from the triage area. By the time she spoke with him, the Security Patrol Officer was wheeling Mr. Sinclair into the Resuscitation Room, where he was pronounced deceased.

FINDINGS

- In considering whether any individual staff acted or omitted to act in a manner warranting discipline, it is important to consider the context of these events. This was truly an exceptional occurrence. The tragedy of a patient dying in the waiting room of an Emergency Department without ever having been triaged has not occurred before. Up until this time, emergency rooms have been organized based on the premise that patients needing care or their escorts will present at triage to be assessed by the Triage Nurse.

- This paradigm has been fundamentally shifted with these events and systems have been changed and further changes may be recommended when the Critical Incident Review process is completed in order to prevent such an occurrence in the future.

- To hold individuals accountable on a disciplinary basis for such gaps in the system would be inappropriate and unfair.

- After an extensive and thorough review, there is no evidence to demonstrate that any individual staff member acted or failed to act in accordance with the expectations of them within the scope of their jobs in a way that would warrant disciplinary action.

- Based on the need now to identify all persons in the waiting area who may be requiring care, there are clearly gaps in the system which are being addressed. None of the staff on duty during that 34 hour period were aware that Mr. Sinclair was awaiting treatment and had not yet been triaged. The assumptions that they made were mistaken. They are each experiencing regret, sadness and frustration reflecting on what might have been had they realized that he was awaiting care and had intervened.

- While disciplinary action is not warranted in these circumstances, ongoing coaching and training to challenge assumptions in order to provide dignity centred care to the whole person will be undertaken. In this case, while not ill-intentioned, assumptions were made about Mr. Sinclair's presence in the waiting room without asking him directly if he was there to see a doctor.

- There have been allegations that in making such assumptions, staff in the Adult Emergency Department demonstrated racism. Racism is a highly charged word, evoking a considerable emotional response and has a number of connotations. The staff of the Adult Emergency Department are hurt, angered and frustrated that they have not been able to tell their story to counteract these allegations. They describe their caring and compassion for a disadvantaged population living in the area surrounding the Health Sciences Centre, who demographically comprise the majority of patients seen in the Adult ER. They passionately describe their efforts to care for those who attend at the Adult ER on a regular basis for shelter,

warmth and food. They spoke of spending their own money to provide a dinner at Main Street Project and to provide Christmas presents for these patients.

- There is no doubt that these gestures of kindness are motivated by good intentions. Unintentionally, however, based on these experiences, assumptions appear to have been made about Mr. Sinclair's presence in the Adult Emergency Department on the weekend of September 19, 2008 by several staff that contributed to them not approaching him directly to ask whether he was waiting to see a doctor. It was unfortunately assumed that he was either there for shelter, as an IPDA patient, had already been treated and discharged or was awaiting a bed.

- Staff in the Adult Emergency Department demonstrate compassion for socioeconomically disadvantaged patients attending at the Adult ER on a regular basis. It is imperative though, from this point forward, that assumptions not be made as to the reason that a person is there and that they be specifically asked if they are there to see a doctor.

PHYSICAL LAYOUT OF THE EMERGENCY DEPARTMENT

- In the spring of 2007, the Emergency Department moved from its space on the first floor of the General Hospital to its current location in the Ann Thomas Building.

- Shortly before moving into the new building, staff expressed concerns about the physical layout of the space, including the location of the Triage Desk and the configuration of the waiting room. In particular, staff were concerned that the waiting area was not visible to the Triage Nurses sitting at the Triage Desk and that some of the chairs were facing away from the Triage Nurses and Security due to the location of the television at the back of the waiting room.

- At that time, management of the Emergency Department and the Executive Team, indicated that while they were open to considering proposals in the future, given that it was a brand new space developed with significant input from the Emergency Program, they needed to get some experience working in the new space before any reconfiguration could be considered. There was no impediment, however, to reconfiguration of the chairs in the waiting room and management of the Department began exploring repositioning of the television several months before Mr. Sinclair's death.

- This notwithstanding, during the interview process, considerable anger was directed towards management for not addressing staff concerns regarding configuration of the waiting room. While this is understood given the staff's perspective, in this particular case, there were several observations of and interactions with Mr. Sinclair and staff, including a Triage Aide, Triage Nurses, and a Nurse Practitioner, a nurse from the Minor Treatment Area, Security Patrol

Officers and Housekeeping Aide. This is not a case where Mr. Sinclair was not seen by staff at all. Regrettably, though, it was not understood by any of the staff observing or interacting with him that he was awaiting treatment.

- Therefore, while the issues regarding the physical space should be and are being addressed, it does not appear that physical space issues were causally connected to Mr. Sinclair's death.

STAFFING ISSUES

- During the interview process, several staff raised the issue of staffing levels in the Adult Emergency Department. It is beyond question that the Health Sciences Centre Adult Emergency is the busiest and most acute Emergency Department in the City of Winnipeg. Regrettably, recruitment and retention of nurses remains an ongoing challenge, with a vacancy rate in excess of 20%.

- Prior to moving into the Ann Thomas Building, the Health Sciences Centre was successful in obtaining funding for a additional nursing position, 24 hours a day, 7 days a week for the Adult ER. Unfortunately, recruitment and retention difficulties continue, as is the case with other Emergency Departments in the City of Winnipeg.

- Due to staffing issues on September 19, 2008, the Observation Unit had to be closed and the Reassessment Nurse had to be re-assigned to the Resuscitation area at approximately 1530 hours, prior to his shift ending at 2200 hours. Staff described that it is not unusual for staff to be shifted within the department to priority areas.

- Recruitment and retention efforts are ongoing and will continue into the future, in collaboration with the Regional Emergency Program Team and Human Resources Specialty Recruitment.

ACTIONS TAKEN TO DATE

The following actions were taken within the first week following the incident to address identified gaps in the system:

- Each person presenting to the waiting room of the Adult Emergency Room is asked if they are requiring medical care. If the answer is yes, a bright green wristband is placed on the individual's wrist by a staff member dedicated to this function 24 hours a day, 7 days a week, to ensure process integrity. At the time of triage, the green band is removed and the normal triage patient identification band is applied. Various staff are currently assigned to perform this function while the process for hiring permanent Registration Clerks is being completed. Once Registration Clerks are in place, a quick registration process will be implemented that can be completed electronically.

- The roles of the Triage Nurses, Reassessment Nurse and Triage Aide are being reviewed with a view to protecting their respective roles and re-assigning and re-aligning tasks that detract from their primary roles.

- A protocol has been implemented requiring primary care clinics sending patients to an Emergency Department to notify the Emergency Department in advance by phone.

- The Triage Desk space and the Registration Desk space are being redesigned to allow for the Triage Nurses and the Registration Clerks to meet together with patients. This will speed the triage and registration processes by minimizing the number of times the patients are asked certain questions. The redesigned space will also provide a better view of the waiting room. Temporary desks will be put into place and process reviews will be undertaken to determine the most effective way to co-locate the Triage and Registration processes.

- Licensed Practical Nurses are being hired to reduce staff vacancies in the Observation Unit.

- Steps have been undertaken to ensure that shift report between nurses and other health care providers is more timely and accurate.

- Staff with social work like experience are being hired to work in the waiting area 24 hours a day, 7 days a week. These staff will interact with all persons in the waiting area on an ongoing basis. They will provide an additional layer of assurance that all patients seeking medical care have been identified but they will also work to assist those in the waiting area who are present for other reasons. While permanent staff are being hired for

this role, staff from the Social Work and Spiritual Health Services Departments are providing some of this support.

- Staff meetings have been and will continue to be held to offer support and information sharing and to gain input into the process and physical changes.
- Seating in the waiting room has been re-arranged and the television moved so that people seated in the waiting room now face towards the Security and Triage area.
- Lighting in the Department has been enhanced to improve staff's ability to clinically/visually assess patients in the waiting room
- The Minor Treatment Area is being modified to allow room for stretchers, so that more patients can be examined in this area and flow through the Department improved.
- Point of Care laboratory testing is being explored as a way of improving flow through the Emergency Department by reducing the wait time for laboratory results.

NEXT STEPS

- The Critical Incident Review Committee process is well underway and recommendations from that process are expected in the coming weeks.
- An Inquest has been called by the Office of the Chief Medical Examiner to consider the facts and circumstances surrounding Mr. Sinclair's death and to make recommendations designed to prevent a death from occurring under similar circumstances in the future.
- The Winnipeg Regional Health Authority and the Health Sciences Centre site in particular are committed to continuing to review and reflect on the changes necessary to improve the Emergency Department system and will respond to the recommendations arising from the Critical Incident Review Committee process and the Inquest in a timely fashion.
- This Report will be reviewed with staff who were on duty during the period that Mr. Sinclair was in the waiting room.
- The Winnipeg Regional Health Authority and the Health Sciences Centre site have been working towards more patient-centred or dignity-centred models of care that include respect and dignity for the whole person, regardless of culture, race, or socioeconomic status. This includes training designed to honour all cultures and training to challenge

assumptions. All staff in the Adult ER will participate in these sessions over a period of time, allowing for appropriate staffing to be maintained in the department.

- The Health Sciences Centre is continuing to take active steps to improve the flow of patients through the Emergency Department.
- The Health Sciences Centre is working with the Regional Emergency Program Team to evaluate actions taken to date to determine what should be applied to other sites within the Winnipeg Health Region.

October 27, 2008

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